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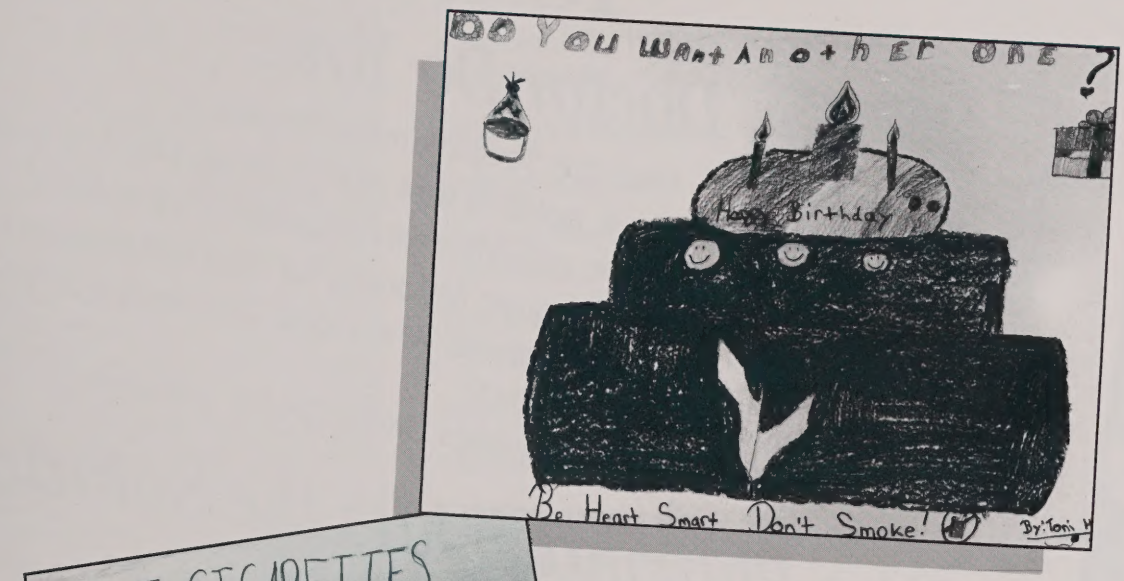
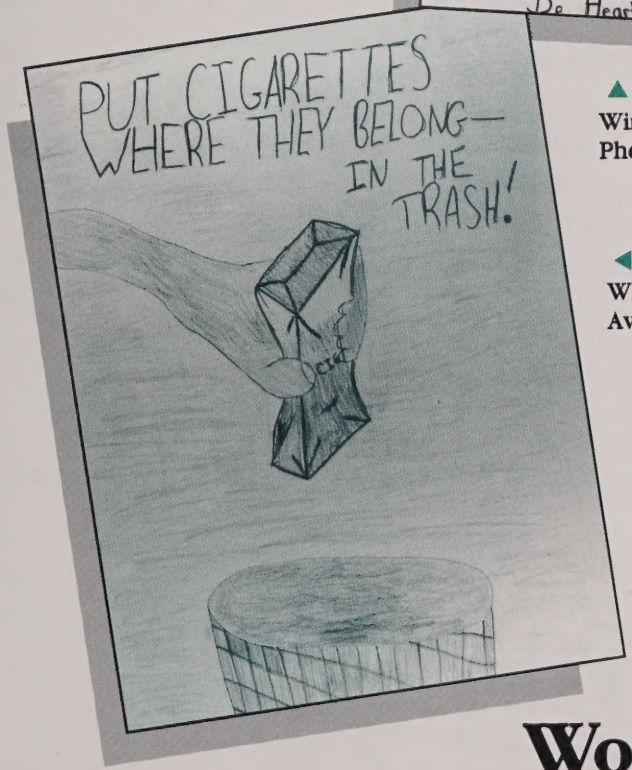


▲ Hampden County Smoke-Free Contest Winning Poster by Toni Harnois, Benjamin Phelps Elementary School in Agawam



◀ Hampshire County Smoke-Free Contest Winning Poster by David Micka, Berkshire Avenue Elementary School in Belchertown

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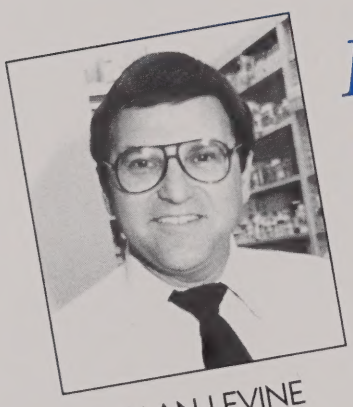

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THE
Hampden Hippocrat
FALL 1996

In This Issue

Anti-Smoking Poster Contest Draws 3500 Entries 3
President's Message 4
Delegates Report 6
Election Results-1996 AMA Annual Meeting 10
The AMA Position-Physician Assisted Suicide 11
Nancy Dickey, MD-Interview 12
Hampden Committee Activities 15
Commentary 17
The Unfinished Symphony 21
New Members Welcome 22

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1996-1997 SEASON

DISTRICT MEETING

PLACE: **THE DELANEY HOUSE**
Route 5 at Smith's Ferry
Holyoke • Massachusetts 01040

DATE: Tuesday, October 1, 1996

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m. SPOUSES ARE WELCOME!

SPEAKER: A. Paul Cellucci
Lieutenant Governor
Commonwealth of Massachusetts

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I shall bring my spouse _____

I shall bring a guest (name) _____

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Anti-Smoking Poster Contest Draws 3500 Entries

Our cover highlights the Grand Prize Winners in the fifth annual "Draw Against Joe Camel Poster Contest." The Grand Prize Winner for Hampden County was Toni Harnois of the Benjamin Phelps Elementary School in Agawam. The Grand Prize Winner for Hampshire County was David Micka of the Berkshire Avenue Elementary School in Belchertown.

Twenty-nine towns and cities in Hampden and Hampshire County participated in this project. Winners were chosen from over three thousand five hundred entries, representing forty-nine schools and one hundred fifty eight third grade classrooms. All participants received a McDonald's gift certificate. Finalists and First Place Winners received an award, a McDonald's gift certificate, and a Mt. Tom Summerside pass. Added to these was a $100 Savings Bond for each Grand Prize Winner.

This poster contest and special classroom curriculum on tobacco control was coordinated for public school third grade students in both counties. This program has been extremely successful in providing both an opportunity for children to understand reasons not to smoke and for the public in Western Massachusetts to learn the hazards of tobacco use through the poster contest, subsequent publicity, public display, awards ceremony, and business community and public education participation.

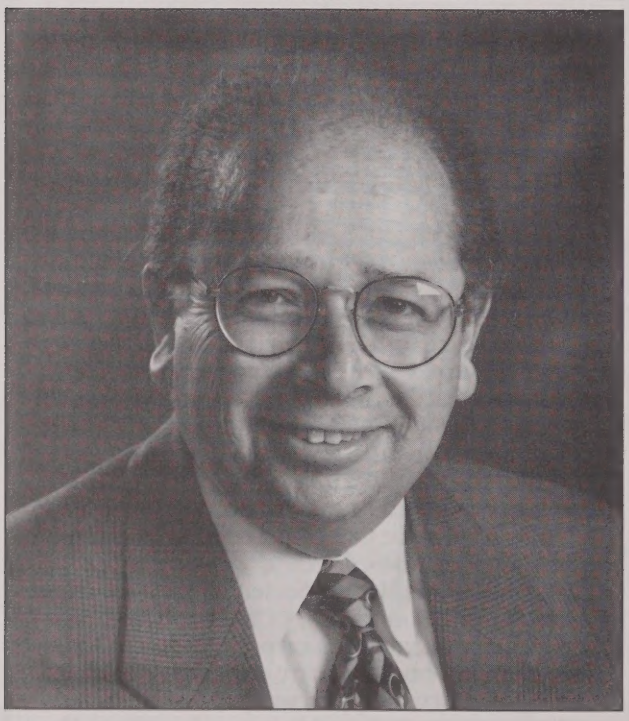
The medical community of Western Massachusetts is dedicated to seeing that children on our geographic region "stop smoking before they start." This demonstration project has been the most successful vehicle to date toward accomplishing that goal. An accompanying curriculum has been carefully researched. The results show that the children grew in knowledge, attitude and intended behavior regarding smoking. The curriculum and research instrument for this project will be presented at the November, 1996 meeting of the American Public Health Association.

"Draw Against Joe Camel" is a collaborative project of the Hampden District Medical Society, the Hampshire District Medical Society, and the American Cancer Society/Pioneer Valley Office, and has been funded under a demonstration project grant by the Massachusetts Tobacco Control Program. Additional funding and in-kind support was provided by both medical societies, McDonald's owner/operators, Mt. Tom Summerside, Elegant Affairs, Fanfare, Springfield Symphony Hall, the Hampshire Mall, Taylor Rental of Holyoke, the Massachusetts Medical Society/Western Massachusetts Regional Office, and volunteers. ■

Project Coordinator	Michael Barnes
Assistant Project Coordinator	Dr. Alvin Winder, M.P.H.
Hampden District Medical Society Chair	Alicia O.M. Ross, M.D.
Hampshire District Medical Society Chair	David Jackson, M.D.
American Cancer Society/Pioneer Valley Office Director	Cynthia Healey
Massachusetts Tobacco Control Program Director	Gregory N. Connolly, D.M.D., M.P.H.

Physician-Assisted Suicide — Is The Handwriting On The Wall?

In the wake of recent court rulings and media and public attention, it is widely believed that physician-assisted suicide will soon be legalized in all states. Late in 1994, Oregon became the first state to approve this measure (but not as yet implemented due to a court injunction). Earlier this year, the Ninth Circuit Court of Appeals ruled that a Washington state ban on assisted suicide violated the due process clause of the 14th Amendment, and the Second Circuit Court of Appeals found that a New York ban violated the Amendment's equal protection clause.



Daniel Dress, M.D., President

Locally, the Sunday Republican weighed in on the 'pro' side in a June 2 lead editorial. And Representative Douglas Petersen of Marblehead has said that he will introduce legislation later this year legalizing physician-assisted suicide in the Commonwealth of Massachusetts.

Although several polls show that the majority of Americans favor legalization of assisted suicide, physicians must remain firm in their opposition to it. In the words of Thomas Reardon, M.D., chairman of the AMA's Task Force on Quality Care at the End of Life, "Asking a physician to assist in suicide transforms the instruments of medicine into tools of death." This, he adds, is fundamentally incompatible with the physician's role as healer. "This should serve as a wake-up call, a message to our profession that we are not meeting our patients' needs."

The tide of public opinion in favor of assisted suicide reflects, in part, a slippage of faith in American medicine. We need to restore that faith. Physicians need to do a better job in striving to identify and address the concerns behind a patient's request for assisted suicide. (Interestingly, an article in JAMA, "Physician-Assisted Suicide and Euthanasia in Washington State", March 27, 1996, found that most of the patients who requested physician-assisted death were most concerned about losing control, being a burden, being dependent, and losing dignity. Intolerable physical symptoms were not the reason most of the patients in this study requested physician-assisted suicide or euthanasia. The authors went on to state that "these findings suggest a need for palliative care to address nonphysical concerns, including the nonphysical aspects of dignity and suffering.")

Very importantly, physicians should be vigilant, in these managed care times, that part of the backing for legalizing physician-assisted suicide might be economically driven. It is a fact that 28% of Medicare expenditures are incurred in the last year of life, and of the Medicare patients who die each year, 50% of funds are spent on their treatment in the last 60 days of life. Managed care plans would save a bundle.

In closing, let me quote Edmund Pellegrino, M.D. of Georgetown University Medical Center: "(The) question is whether any law or legislative act can relieve health professionals of their ethical responsibilities. History teaches how important it is for a profession to protect its ethical integrity if it is not to become an instrument of political purposes. Professional ethics must be grounded in something more fundamental than social convention." ■

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- malpractice claims due to inadequate informed consent?
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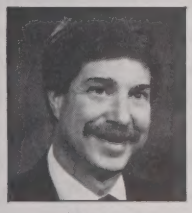

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1996 Annual Meeting Of The House Of Delegates

by Alan M. Harvey, M.D., MBA
Alternate Delegate to AMA, Massachusetts

Introduction

- The AMA House of Delegates met in Chicago, June 23-27, 1996.
- There were 430 delegates seated at the opening session of the House. On Tuesday, the delegates approved the applications for 12 additional specialty societies, granted one bonus delegate to two specialty societies that have unified membership with the AMA, and gave seats to three national medical societies: American Medical Women's Association, American Osteopathic Association, and the National Medical Association. With these changes there will be 447 voting delegates at the Interim Meeting:
- The House agenda contained 104 reports and 210 resolutions.

A wide array of issues were considered in socio-economics, science, medical education, public health and the structure of organized medicine, including future representational issues in the House of Delegates. The following are the highlights of the major issues considered at the meeting.

Study Of The Federation

The House considered a subsequent report of the Federation Study that offered far-reaching changes in the structure and operation of the various levels within organized medicine. Among the recommendations approved by the House were:

1. The development of a "Statement of Collaborative Intent" that respects the autonomy of constituent organizations, but also characterizes the nature of the working relationships that must exist among members of the new Federation if it is to achieve its objectives.
2. The recognition of a special need for coordinated action with regard to public policy activities for organizations represented in the AMA/Federation House of Delegates.
3. The establishment of a means to identify the best approach to incorporating special-interest medical associations and mode of practice organizations into the AMA/Federation House of Delegates.
4. The development of active outreach efforts to identify mechanisms and processes for increasing the participation of certain segments of the membership i.e. women physicians, solo practice, IMG's, minority physicians, research physicians, employed physicians.
5. The establishment of a Federation Coordination Team to clarify roles and achieve active coordination of efforts in the Federation and to establish a process for pursuing collaborative efforts among Federation members. Procedures for the selection and operation of the FCT were established and the House called for all Federation units to provide financial support through annual contributions based on their total membership levels.
6. The establishment of a new delegate allocation formula that will provide more representation from specialty societies in the AMA House of Delegates. This new procedure includes:
   A. Once a year, the AMA will send a specialty-representation "ballot" to each AMA physician member, plus fourth-year medical student members, asking each member to identify on the ballot one specialty society to represent him or her in the AMA/Federation House of Delegates for the next year.

B. The specialty-representation ballot will indicate that physicians should be members of the specialty society which they select on the ballot to represent them in the AMA/Federation House of Delegates.

C. For the first three years, the number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 2000 AMA members, or portion of 2000 AMA members, who select that particular specialty society on the annual ballot and return to the AMA.

D. Starting in the fourth year, specialty society delegate allocation will be on the basis of one for each 1000 members or fraction thereof.

E. Each specialty seated in the House will be allocated at least one delegate.

This balloting process will commence in the Fall of 1996 and will serve as the basis for the 1997 delegate allocation.

Counseling and Testing of Pregnant Women for HIV

After extensive debate in the Reference Committee and on the floor of the House, the House approved a stronger policy on HIV testing of pregnant women by adopting an Oklahoma resolution that states:

> Resolved, that the AMA support the position that there should be mandatory HIV testing of all pregnant women and newborns with counseling and recommendations for appropriate treatment.

HIV Related Actions

The House amended then adopted a report of the Council on Scientific Affairs with the following positions:

1. That the AMA continue to promote the physician's office and other medical settings as the preferred settings in which to provide HIV testing.
2. That the AMA encourage physicians to make HIV counseling and testing more readily available in medical settings.
3. That the AMA monitor the use and efficacy of HIV home collection test kits as well as their impact on public health efforts to control HIV disease and reassess current AMA policy on HIV home test kits with a report back at the 1996 Interim Meeting.

Continued on next page

Left to right: Trina Deitz, MSPT; Catherine Buelow, MBA, PT; Patricia Raymond, Rehabilitation Aide; and Donna Buchanan, PTA

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Delegate's Report

Continued from previous page

The House amended then adopted a Board of Trustees report on mandatory testing of semen donors with the following positions:

1. That the AMA support CDC, FDA, and The American Society for Reproductive Medicine {ASRM} policy mandating HIV testing for anonymous semen donors.
2. That the AMA encourage a uniform standard of mandatory HIV testing of semen donors that incorporates established CDC, FDA, and ASRM guidelines and responds to FDA regulations currently under review.

Physician-Assisted Suicide

The House considered a Board report and four resolutions on physician-assisted suicide. This issue captured the attention of the public media and the House deliberations were widely reported.

The delegates voted to reaffirm policies in opposition to physician-assisted suicide and spelled out additional activities for the AMA:

1. That the AMA initiate an educational campaign to make palliative treatment and care directions, based on values-based advance care planning, the standard of care for meeting the needs of patients at the end of life.
2. That the AMA continue to seek out opportunities to present the views of medicine on physician-assisted suicide and improving the quality of care for patients at the end of life.
3. That the AMA work with local, state, and specialty medical societies to develop programs to facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life, and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life.
4. That the AMA disseminate this report throughout the federation with a request that it be distributed to local physicians.
5. That the Board of Trustees present the House of Delegates with an update on these and related activities at the 1996 Interim Meeting and the 1997 Annual Meeting.

Point of Service Provisions in Managed Care Plans

The House continued a debate on mandatory point of service provisions that has spanned the last three meetings of the House of Delegates. The Reference Committee reported that there were those in support of a policy that point of service provisions should be included in all health benefit plans that restrict access to physicians through closed panels or similar managed care techniques. These members advocated that "automatically" including a POS feature in every health benefit plan is the ultimate guarantee that patients will have a choice of physicians and will receive quality care.

Those opposed to mandatory POS features argued that this would require rescission of extensive and long-standing AMA policy on pluralism and would actually decrease patient choice by prohibiting a patient from freely choosing health care coverage. After much discussion the delegates voted to reaffirm existing AMA policy that states:

> That the AMA take all appropriate action to require all health plans or sponsors of such plans that restrict a patient's choice of physicians or hospitals to offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, and optional "point-of- service-type" feature so that patients who choose such plans may elect to self-refer to physicians outside of the plan at additional cost to themselves.

Medical Services Aboard Cruise Ships

The Florida delegation introduced a resolution pointing out the lack of adequate medical services aboard some cruise ships. Support for the AMA to get involved with this issue was heard from all who spoke in the Reference Committee. The House amended then adopted a resolution stating:

1. That the AMA, through federal legislation or international treaty as appropriate, urge the development of standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports.
2. That the AMA provide information to the AMA membership through its publications in order to increase physician and patient awareness of the limited medical services and resources aboard cruise ships which would adversely impact the patient's health status.

Ultimate and Extreme Fighting

In an extension of AMA's opposition to boxing and violence, the Pennsylvania delegation introduced a resolution opposing ultimate and extreme fighting. The House amended then adopted the resolution calling on the AMA to:

1. Oppose ultimate fighting and extreme fighting events.
2. Encourage states which have not banned these events to pass a law doing so.
3. Study the feasibility of encouraging federal or state prohibitions on media broadcasts of these events.

Tobacco Advertising

The Hawaii delegation introduced a resolution on advertising tobacco in magazines, which decried the presence of these magazines in physicians' waiting rooms. The House adopted a substitute resolution calling on the AMA to:

1. Urge physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products.
2. Recommend to its members that they not subscribe to magazines that advertise tobacco products.
3. Again disseminate its list of magazines that do not publish advertisements for tobacco products.

Conclusion

AMA house meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the AMA may present testimony at the Reference committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you cannot come to the meeting, you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the AMA House of Delegates. Your delegates know how to best carry forth your point of view.

Thank you for giving me this opportunity to present this report. I will be happy to respond to any questions. ■

Election Results - 1996 AMA Annual Meeting

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Richard F. Corlin, MD

VICE SPEAKER, HOUSE OF DELEGATES
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William H. Mahood, MD (for term ending 1997)
Donald J. Palmisano, MD

COUNCIL ON CONSTITUTION AND BYLAWS
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Cecil B. Wilson, MD

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COUNCIL ON MEDICAL SERVICE
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William A. Fogarty, MD
Cyril M. "Kim" Hetsko, MD
Joseph M. Heyman, MD
F. M. "Mac" Mauney, Jr., MD (for term ending 1997)

COUNCIL ON SCIENTIFIC AFFAIRS
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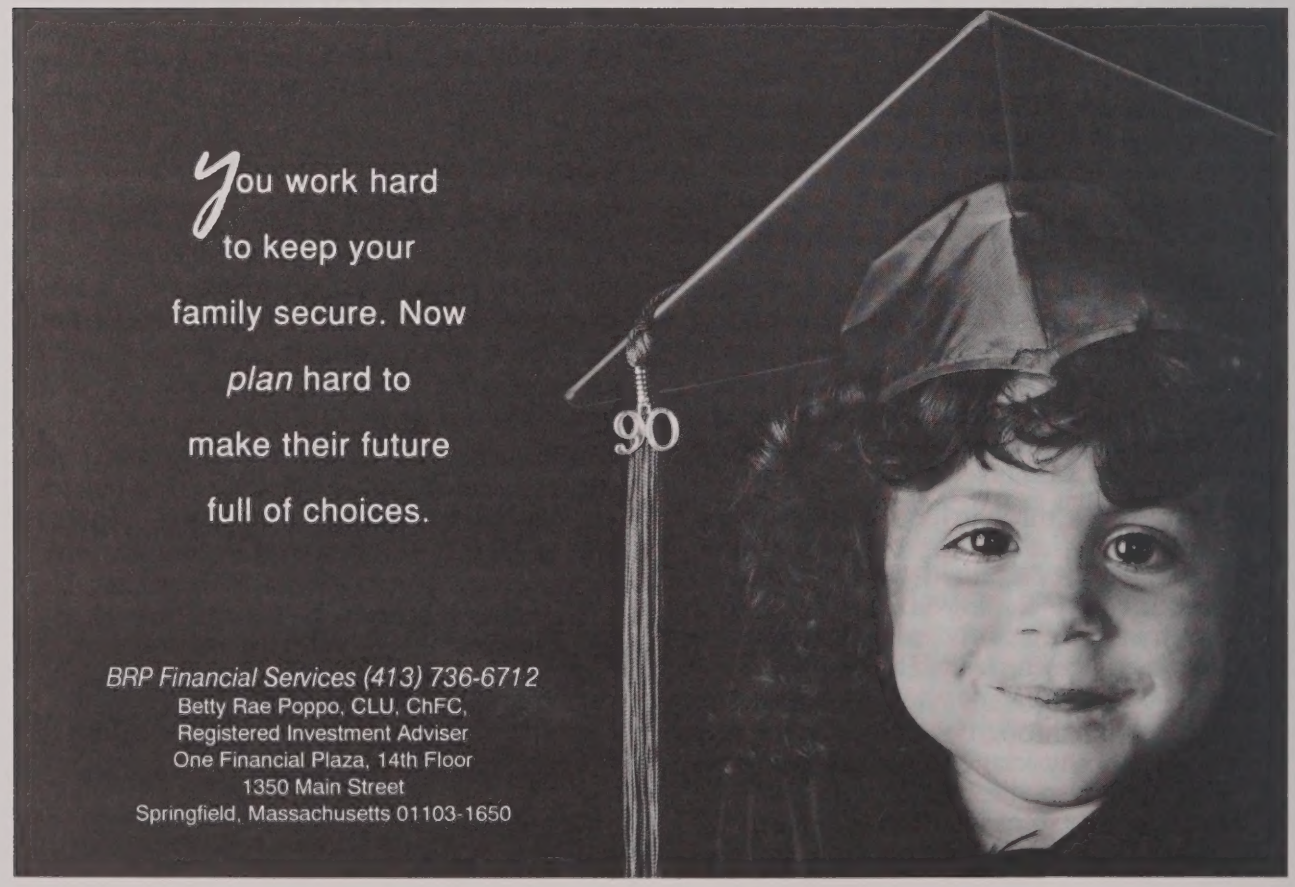
Scott D. Deitchman, MD
John P. Howe, III, MD
Nancy H. Nielson, MD



American Medical Association

Physicians dedicated to the health of America

THE AMA POSITION – PHYSICIAN ASSISTED SUICIDE

As a physician, I am **devoted to healing and to relieving suffering**. I am obligated and committed to helping patients in their remaining days. I cannot be the cause of their death, nor can I assist them in causing their own death.

The fear associated with physical suffering, with losing control and with being a burden to or dependent upon others is understandable. However, **the realities of death are a critical foundation of life. If we literally remove individuals from having to deal with these realities, it could have serious ramifications for society as a whole.**

My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, perceive to be the value of their remaining life. Make no mistake, **when it comes to caring for my patients' health and welfare, I am their trusted ally**. My patients can have faith that I will do all I can to assure that their passing is dignified and comfortable.

I am acting in the best interests of my patient if, while attempting to alleviate suffering and maximize his or her comfort, death is hastened. However, if **the intent of my actions** goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical. Death is rarely immediate when it is not actively caused. But, **the dying process can take place in comfort and with dignity**.

In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, **the issue is one of intent**. By removing artificial life-support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially sustained life, not to cause death.

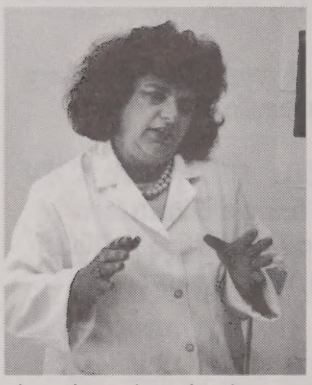
Physicians who have cared for patients and their families until and beyond death experience **among the most rewarding aspects of medical practice**. Death is often the most meaningful chapter of a patient's life, difficulties notwithstanding. Physician assisted suicide jeopardizes this important experience.

The American Medical Association believes the appropriate answer to physician assisted suicide is improved care through a better informed medical profession and public. We must work together to **ease the dying process and preserve the significance of experiencing life's final stages**. Physicians have reported that patients requesting physician assisted suicide drop the idea once they understand that comprehensive planning and palliative care are available; **that their life has worth; and that they won't be abandoned.**

We will continue our dialogue with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical suffering and the psychological needs of patients at the end of life. We will work diligently to inform patients on the alternatives to physician assisted suicide, including hospice care. However, **the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.**

Our overall goal is to develop an acceptable, reasoned, and realistic approach to re-directing patient requests for suicide that is based on sound ethical principles and optimal clinical care.

Nancy Dickey, MD
AMA Board Chair discusses Physician-Assisted Suicide



Photos by: Ted Grudzinski

What is the AMA's overall position on the issue of physician-assisted suicide?

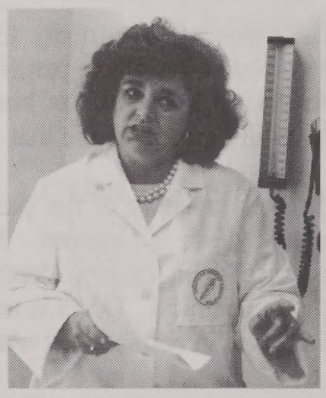
Physicians are devoted to healing and to relieving suffering. As your doctor, I am obligated and committed to helping you in your remaining days. I cannot be the cause of your death, nor can I assist you in causing your own death.

What is the AMA's underlying concern on this issue?

The heart of our concern is placing physicians in the position to actively end their patients' lives. My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, might perceive to be the value of their remaining life. Make no mistake, when it comes to caring for my patients' health and welfare, I am their trusted ally.

Does the AMA's Code of Medical Ethics represent all physicians?

Like all individuals, physicians do have a range of personal opinions on various issues. However, the Code of Medical Ethics, which is maintained by the AMA's Council on Ethical and Judicial Affairs, is widely followed throughout the country. It is cited regularly by State Medical Boards when determining standards of practice for the medical profession. In addition, the AMA's House of Delegates reviews and approves all ethical opinions contained in the Code of Medical Ethics. Because the House of Delegates represents, in one way or another, nearly 98 percent of the physicians in America, the Code of Medical Ethics is truly representative of



medicine's position with regard to ethical opinions.

How do you respond to critics who say the AMA's position on physician-assisted suicide does not consider patient fear and desire for dignity at the end of life?

Fear associated with physical suffering, with losing control, with being a burden to or dependent upon family members, and with losing dignity is an understandable reality. The medical profession has not concentrated on these issues to the necessary degree. But, we feel the appropriate alternative to physician-assisted suicide is improved care through a better informed medical profession and public, working together to ease the dying process. I will use all of my skill and knowledge to relieve your suffering, I will get you the help you need to come to terms with death. But, I cannot help you kill yourself.

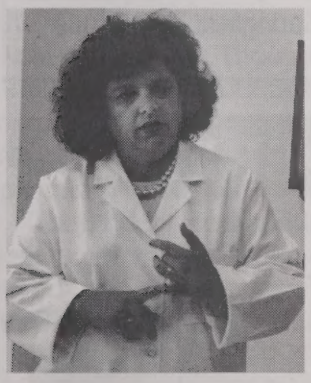
How does the AMA distinguish between controlling pain even if it causes death and assisted suicide?

The distinction is based on the intent of my actions. I am acting in the best interests of my patient if, while attempting to control suffering and maximize his or her comfort, death is hastened.

However, if the intent of my actions goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical.

Isn't that a fine line?

In some cases it may be a fine line. Usually, however, the intent is very clear. Regardless, if a line is to be drawn, intent to comfort vs. intent to kill is one line physicians must not cross.



How does assisted suicide through pain medication differ from death caused by removal of treatment/life support?

In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, the issue is one of intent. By removing artificial life support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially-sustained life, not to cause death.

How do you respond to recent court decision in California (9th Circuit), which states that physician-assisted suicide is a Constitutional right?

First of all, nowhere in the Constitution does it state that individuals have a right to have their doctor kill them if they so choose. We find this interpretation to be rather illogical. Second, these and future rulings do not change the ethic of the medical profession which clearly states that physicians should not assist in suicide.

Will the AMA appeal these and other Court decisions?

We will do whatever is necessary to ensure that physicians are not put in a position to kill, and that patients die in comfort and with dignity. If this means appealing directly or submitting amicus briefs or offering verbal

or written testimony in support of an appeal, we will do so. In addition, the AMA is mounting a major information-based campaign to educate and inform the courts, the media, physicians and the general public about the alternatives to physician-assisted suicide, including hospice care.

Will the AMA consider changing its policy regarding physician-assisted suicide?

We will continue our discussions with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical pain and the psychological needs of patients at the end of life. We will work diligently to enlighten patients on the alternatives to physician assisted suicide, including hospice care. However, the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.

How does the AMA feel about the $10 million defamation suit brought against you by Jack Kevorkian.

Let's make a distinction here. Notwithstanding our position on physician-assisted suicide, Jack Kevorkian's actions are reprehensible. Even most proponents of physician-assisted suicide are appalled by his activities. Abandoning bodies in parking lots falls well short of our societal expectations for death with dignity. With regard to the lawsuit, we feel that it is nonsense. We will not be silenced on an issue so critical to the welfare of our patients. ◆

Interview by Mark Wolfe

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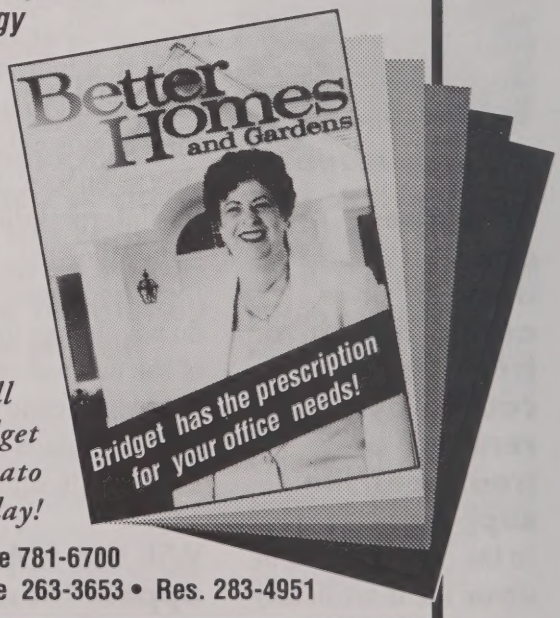

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Hampden Committee Activities

The Medico-Religious Committee continued planning for the 12th Annual Medical Ethics Seminar. The panelists for the evening will include Attorney Theodore Brown from the law firm of Egan, Flanagan and Cohen, Ms. Marcia Palmer, R.N., Managed Care for Mercy Hospital, Ms. Judith Plotkin-Goldberg, chair of the Board of Trustees for Baystate Medical Center, and Rabbi Herbert Schwartz from the Temple Beth El. The Council of Churches distributes a booklet titled, "Knowing My Neighbor". The booklet enables caregivers of the sick -whether professional or family members - to have information about a patient's religion or culture. This booklet will be available at the seminar for the cost of $3.00 each.

The Public Health Committee continued their community support by once again participating in the "Our World" program sponsored by Junior Achievement. Dr. Thomas O' Neil and Dr. Alonzo Sheffield spoke to the sixth grade students in the Springfield and West Springfield school systems about the importance of staying in school and planning for a career.

The Student Health Video tape on the subject of teen pregnancy and sexually transmitted diseases stands ready for use in the school system this fall. Physician members of Hampden District Medical Society have volunteered to serve as facilitators when the tape is shown in the classrooms.

The Executive Committee looks forward to positive input from the four new members who have joined the committee. They are Doctors J. Michael DeCenzo, Timothy Fitzpatrick, Claudia Koppelman and Jean Talati. The committee was informed of the mailing sent to the homes of all members asking for interest in re-establishing the HDMS Alliance. Those who responded will be sent a second mailing to see if the group would be willing to take on one special project.

On June 9, 1996, a House Calls program was held on the topic of Osteoporosis. This program once again proved to be a resounding success, with close to 1,000 calls from the general public being fielded. Future programs are being planned for the Fall.

The Second Annual Girl Scout Mentor Program was held on June 27, 1996. Eight women physicians met with their respective Girl Scout "intern" at the orientation breakfast held in the Mercy Hospital Deliso Center. The Girl Scouts spent a full day with their physician mentor before attending a reception back at the Deliso Center. The girls and physicians both had the chance to relate their experiences of the day. ■

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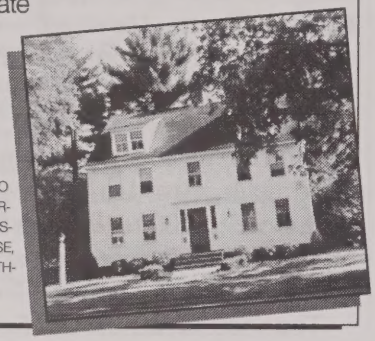

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Commentary

A Small Town Responds To Health Care Changes

Francis D. Horrigan, M.D., Editor

The past decade has witnessed a rapid evolution in health care in delivery (thrombolytic therapy and laporoscopic surgery are examples), research (elucidation of the genome), and administration (megacorporations forming vast provider networks). In a few short years the private sector preempted health care from government initiative to the control of administrative corporations, managed care plans, and an array of pricey consultants advising us what to do with them. Typically these organizations are characterized by high profits for their top people and short lifespans as they partake of acquisitions and re-acquisitions resulting in difficulty in coping at the local level. This uncertainty produces certain effects in smaller communities, some obvious, some obtuse, but all shared to some extent around the country. Small communities tend to have a strong sense of community identity and self-sufficiency. The smaller size promotes familiarity among its residents facilitating developing solutions for community needs more easily than can be done in large cities.

> Hopefully the vigorous responses of small community citizens, doctors and hospitals will keep health care like politics - local.

My purpose is to describe some responses in my community to the present health care environment with a focus on our hospital, the physician community and the community at large demonstrating some actions required because of being small as well as the flexibility that smallness offers in developing effective responses.

Our hospital has served the community for a hundred years. It recognizes that certain costs and inefficiencies in inpatient care are no longer sustainable. New models must be developed which deliver quality care in cost efficient ways. In small communities the hospital is a major industry in terms of expertise, capital, equipment, and as a large employer. Small hospitals respond to these pressures in a number of ways which affirm their community-based strengths. Examples include:

1. downsizing inpatient units
2. developing outpatient or same-day services
   Our hospital is developing a "surgicenter"
   which incorporates much needed upgrades in OR technology, an on campus location designed to coordinate ancillary and emergency services and a pleasant efficient atmosphere for our patients and physicians.
3. developing a community health system to include home services such as nursing, PT, OT, social services, and hospice
   mental health care, in and outpatient rehabilitation, in and outpatient long term care opportunities, maternal and child health
4. develop solutions responsive to the practical limitations of small size
   outsourcing certain services
   affiliation with larger entities gaining access to specialized services a small hospital cannot support, increasing the service base of the larger entity, and maintaining identity with autonomy.

The physician community shares theme of being small and self sufficient so that, with the

Continued on next page

Commentary

Continued from previous page

hospital resources, it can deliver quality, cost efficient care. Small size limits depth and diversity so that we depend on outside sources for some services. Large insurers like to link with large provider groups to produce efficient negotiations (usually of the take it or leave it variety). This, in turn, means that doctors and hospitals have to form large groups to avoid being trampled (or worse, ignored). In our community a physician-hospital organization has secured contracts keeping covered lives (formerly patients) in town. The increasing size of "plan" corporations and the emphasis on primary-care gatekeepers has led both primary and specialty physicians to form IPA groups or groups without walls which can evolve from loose coverage groups using various similar medical support services to more formal legal entities sharing common policies, procedures and administration across several locations. An ophthalmology surgicenter in our area exemplifies what a group of subspecialists can accomplish. A broader geographic base of many practices enables the subspecialist to deliver care in a setting which, because of its single focus, offers a very high level of expertise and efficiency for defined problems.

The community at large responds to all this in a variety of ways. Some are macroeconomic: employers seek insurance plans that maximize their success. Some ways are predictable on a smaller scale such as volunteerism as aides, providers, or board members, all of whom help make the system work for the community. Some activities are generated from the grass-roots to transcend obstacles generated by even the most well-intentioned institutions. Examples include community-sponsored events to fund transplants for people who would not otherwise get them. A recent example in our community is the development of the Center for Hope at Noble. This is a cancer support group of very ambitious proportions. While the hospital has always sponsored or been supportive of groups for several diseases, including cancer, a lady in our town recognized the need, through personal experience, for a more comprehensive and humanistic approach. She had no success in a larger community. Some friends who shared her ideas encouraged her to try locally. In short order she secured the support of the hospital, several local businesses, several physicians, and some very dedicated lay people. The result was a homey, non-institutional site which can provide support, access to physical services, education and professional counseling. Another lady has generated a group to help people with inflammatory bowel disease.

The activities I have described are not unique to my community. Other, perhaps more creative, responses are going on all over the country. It would be very easy to lose control of our health care to ever larger insurance and provider networks which by sheer size could stultify the whole system. Hopefully the vigorous responses of small community citizens, doctors and hospitals will keep health care like politics - local.

I would like to thank Gaetana Aliotta, Mary O' Neil, Sandy White and Ted Krawiec for their contributions to this article. ■

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The Unfinished Symphony

By Untitled

The president of a large managed health care facility also served on the board of his community's symphony orchestra. Finding that he could not go to one of the concerts, he gave his tickets to the company's director of health care cost containment. The next morning, he asked the director how he enjoyed the performance. Instead of the usual polite remarks, the director handed him a memo which read as follows:

The undersigned submits the following comments and recommendations relative to the performance of Schubert's "Unfinished Symphony" by this city's symphony orchestra as observed under actual working conditions:

A. The attendance of the conductor is unnecessary for the public performances. The orchestra has obviously practiced and has the prior authorization from the conductor to play the symphony at a predetermined level of quality. Considerable money could be saved merely by having the conductor critique the orchestra's performance during a retrospective peer review meeting.

B. For considerable periods, the four oboe players had nothing to do. Their numbers should be reduced and their work spread over the whole orchestra, thus eliminating peaks and valleys of activity.

C. All 12 violins were playing identical notes with identical motions. This is unnecessary duplication: the staff of this section should be cut drastically with consequent savings. If a large volume of sound is required, this could be obtained through electronic amplification, which has reached high levels of reproductive quality.

D. Much effort was expended playing 16th notes or semi-quavers. This seems an excessive refinement, as most listeners are unable to distinguish such rapid playing. It is recommended that all notes be rounded up to eighth. If this is done, it would also be possible to use trainees and lower grade musicians with no loss of quality.

E. No useful purpose would appear to be served by repeating with horns the same passage that has already been handled by the strings. If all such redundant passages were eliminated, as determined by the utilization review committee, the concert would have been reduced from two hours to about 20 minutes, resulting in substantial savings in salaries and overhead. In fact, if Schubert had addressed these concerns on a cost containment basis, he probably would have been able to finish this symphony! ■

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Specialty: Dermatology

Caren S. Ferris, M.D.
20 Hospital Drive
Holyoke, MA 01040

Born: May 5, 1959
Premed: Wellesley College, Massachusetts 1976-1980
Medical: Mt. Sinai School of Medicine, New York 1980-1984
Internship: Mt. Sinai Medical Center 1984-1985
Residency: Mt. Sinai Medical Center 1985-1988
Specialty: Psychiatry

Bernita M. Spagnoli, M.D.
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1233 Main Street
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Fellowship: Massachusetts General Hospital 1987-1988
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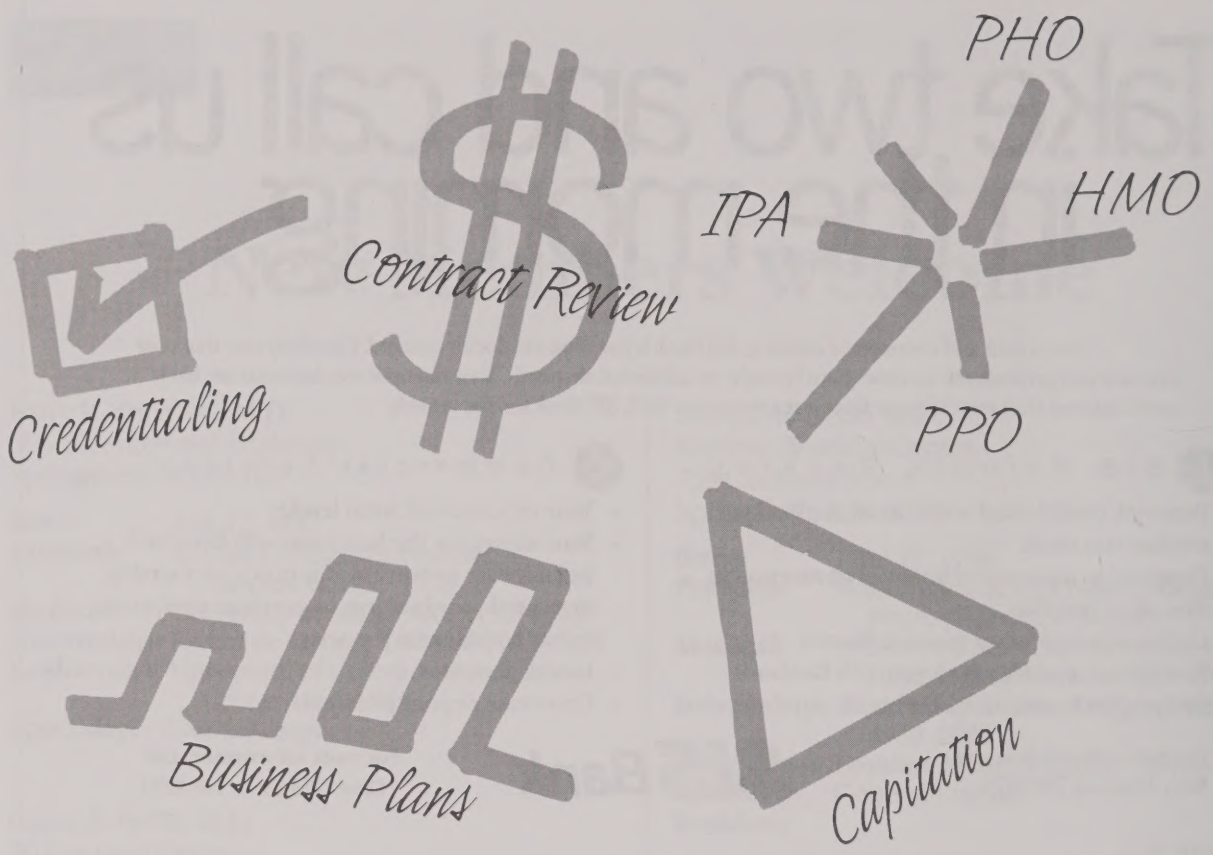

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